TOMBALL REGIONAL
INTERNAL MEDICINE
ASSOCIATES
13414 Medical Complex Drive, Suite 6, Tomball, TX 77375
p) 281-516-0212   f) 281-255-3320   www.tomballinternalmedicine.com

PRE-APPOINTMENT CHECK LIST

Welcome to Tomball Regional Internal Medicine Associates! In order to facilitate the registration process, we have provided an easy checklist for your convenience to help you expedite the process of getting established as a new patient. Please include all information below to ensure that we will be able to accommodate you as a new patient in the best way possible.

_________ **IDENTIFICATION:** Bring your insurance card and photo I.D.

_________ **NEW PATIENT PACKET:** Please fill out all forms completely and remember to sign it.

_________ **MEDICATIONS:** We are asking that you bring all medication bottles to your appointment (including over-the-counter medications and supplements). This is imperative in verifying medication doses and preventing communication errors.

_________ **MEDICAL RECORDS:** If you have copies of your previous medical records, (Vaccination documents, Imaging Reports, etc), Please bring these documents with you. You will need the names and phone numbers of all physicians that you see/have seen, so that we can request your medical records.

_________ **POWER OF ATTORNEY (POA) FORMS** *(if available)*

_________ **LIVING WILL AND/OR DNR FORMS** *(if available)*

Our goal is to exceed your expectations each time you visit our office. In order to provide an efficient, productive patient experience, a nurse will review as much information as possible prior to your visit with the physician so we request that you arrive one hour prior to your physician appointment.

We look forward to working with you.

Sincerely,

The providers and staff of Tomball Regional Internal Medicine Associates

YOUR APPOINTMENT IS SCHEDULED FOR ____________________ AT ____________________.

PLEASE ARRIVE BY ____________________________.

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ACQUAINTANCE FORM

Please fill out completely and clearly. All information is REQUIRED. Thank you!

Name: ______________________________ Age: ________ Birthdate: ____________

Mailing Address: ______________________________ City __________ State/Zip__________

Home Address: ______________________________ City __________ State/Zip__________

Phone (H) ______________ (W) ______________ (C)______________

Email: ______________________________

Sex: M F Race: __________ Marital Status: S M D W Separated

SS #______________________ Driver's License #______________________

Employer ______________________________

Address: ______________________________ City __________ State/Zip__________

Referred By ______________________ Relationship ______________

Emergency Contacts:

Name: ______________________ Phone: ______________ Relationship: ________

Name: ______________________ Phone: ______________ Relationship: ________

Insurance Information:

Primary: ______________________ Group # __________ ID# __________

Policy Holder: ______________________ SS# ______________ DOB __________

Employer: ______________________ Phone ______________________

Secondary: ______________________ Group # __________ ID# __________

Policy Holder: ______________________ SS# ______________ DOB __________

Employer: ______________________ Phone ______________________

I assume full responsibility for payment of all service rendered not covered by my insurance plan.

I authorize payment of medical benefits to the above named provider.

I authorize the release of medical information/records to my health insurance company for the purpose of obtaining payment for services.

Signature: ______________________________ Date: ______________

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NAME: ______________________ PHYSICIAN: ______________________

DOB: ______________ AGE: ________ APPT. DATE: ______________________

1. REASON FOR APPOINTMENT TODAY:

____

2. ALLERGIES or intolerance to medications?

□ NONE (If yes, to what & what reaction?)

____

____

3. MEDICATIONS:

□ Check box if you **do not take** any prescription or over the counter medications.

□ Check box if you brought your medications, vitamins, and supplements to this appointment.

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS THAT YOU ARE TAKING:

MEDICATION NAME	MEDICATION DOSE	HOW OFTEN (ex: once/day)

4. IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) _________ (Tdap) _________ Influenza (flu shot) ___________ TB ___________

Covid-19 (#1) ________ (#2) _______ (#3) ________ pneumonia (#1) _________ (#2) ____________

Shingles (#1) _______ (#2) ________ Influenza (flu shot) ____________ TB ______________

5. MEDICAL CARE TEAM:

Please list **ROUTINE** healthcare providers & their specialty: (ex: cardiologist, ophthalmologist, etc.)

NAME	SPECIALTY	PHONE / FAX / ADDRESS

List Pharmacy information and any medical suppliers you use (e.g. respiratory supplies, etc):

SERVICE / DEVICE	COMPANY NAME	PHONE / FAX

6. MEDICAL FORMS: Please check any of the following forms you have completed:

□ Advance Directive for Health Care (ADHC)
□ Durable Power of Attorney (DPA) for healthcare decisions
□ Living Will
□ OTHER: ____

□ **Would you like more information about these forms? (circle) YES NO**

7. PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disorder
- ☐ Bronchitis
- ☐ CAD
- ☐ Constipation
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hyperglycemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ IBS
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Pneumonia
- ☐ Polio
- ☐ Prior MI
- ☐ Prostate Problems
- ☐ PUD
- ☐ Renal Disorders
- ☐ Stroke
- ☐ Taking Blood Thinner
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Upper GI Bleeding

☐ Cancer: ________________

8. SURGICAL HISTORY:

DATE:	PROCEDURE

9. HEALTH MAINTENENCE:

	Date		*Date*		*Date*
Colonoscopy		EKG		Last Dental Exam	
Cologuard		Pacemaker Check		Last Diabetic Foot Exam	
Bone Density		Last Cervical Pap		PSA level (male)	
Mammogram		Last Vaginal Exam		HgbA1c Blood Test	
Stress Test		Last Eye Exam		Urine - MicroAlbumin	

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

10. SOCIAL HISTORY:

Tobacco Use:
□ Never used tobacco □ Current User
□ Former User: Quit date: ________

Smoke/smoked (circle)?
Cigarettes / Pipe / Cigars / Smokeless Tobacco

Packs/day: ________ # of years: ________

Alcohol Use: Do you drink alcohol?
□ No □ Yes Quit date: __________
# of drinks/week: __________
□ Beer □ Wine □ Liquor

Caffeine Use: Do you consume caffeine?
□ No □ Yes # of drinks/week: __________
□ Coffee □ Soda □ Tea □ Chocolate

Drug Use: Have you ever used recreational drugs?
□ No □ Yes □ Quit date: __________

If yes, which ones? ______________________
Any used currently? ______________________

Exercise: Do you exercise regularly? □ No □ Yes
If yes, what kind of exercise?

____

____

# of minutes/day: __________

# of days/week: __________

Occupation (or prior occupation): □ retired

____

Education (highest level of education):

____

Marital status: □ single □ partner
□ married □ divorced □ widowed

Physical Disabilities:
(Please indicate disabilities below)
□ Severe Visual Impairment
□ Severe Hearing Impairment
□ Severe Speech Impairment
□ Severe Memory Impairment
□ Bed-bound
□ Requires assist to walk
□ Wheelchair dependence
□ Other:

____

Activity of Daily Living: (check all that apply)
□ difficulty feeding oneself
□ difficulty dressing oneself
□ difficulty bathing oneself
□ difficulty grooming oneself
□ difficulty with toileting needs
□ difficulty communicating
□ difficulty cleaning house
□ difficulty managing money
□ difficulty with mobility
□ Independent with all daily activities

Sexual Activity: Are you sexually involved:
□ Not currently □ Never □ Yes

Birth control method or STD prevention:
(check all that apply):
□ None needed □ Condom □ Pill
□ IUD □ Patch □ Ring
□ Diaphragm □ Vasectomy
□ Tubal ligation □ Other method
(specify):____________________

11. WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Last Menstrual Period: ______ Age at end of periods (menopause/hysterectomy): ______ Year: ________

Gestational Diabetes? (circle one) NO YES - If yes, When? ______________________________

12. FAMILY HISTORY

Adopted? ☐ No ☐ Yes If adopted and you do not know your family history skip the Family History section and continue to Review of Symptoms on the next page.

	Year of Birth	Year of Death	Health Issues	Cause of Death
Mother				
Father				
Brother #1				
Brother #2				
Brother #3				
Sister #1				
Sister #2				
Sister #3				
Other: ___________				

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Notes:*
No known health problems					
Alcoholism / Drug abuse					
Alzheimer's / Dementia					
Asthma					
Autoimmune Disease					
Bleeding Disorders					
Cancer (explain)					
Depression / Anxiety					
Diabetes Type I (childhood onset)					
Diabetes Type II (adult onset)					
Emphysema (COPD)					
Genetic Disorder (explain)					
Glaucoma / Cataract					
Heart Attack, Angina (Coronary Artery Disease)					
Heart Disease (CHF)					
Hyperlipidemia – high cholesterol					
Hypertension – High blood pressure					
Kidney Disease					
Liver Disease					
Macular Degeneration					
Osteoporosis					
Stroke / TIA					
Thyroid Disease					

SYSTEM REVIEW (Current symptoms or concerns) *Check all that apply*

SYSTEMIC SYMPTOMS
- [ ] WEIGHT CHANGE
- [ ] CHILLS
- [ ] FEVER
- [ ] NIGHT SWEATS
- [ ] FEELING TIRED / POORLY

HEAD SYMPTOMS
- [ ] HEADACHE
- [ ] FACE PAIN
- [ ] SINUS PAIN

EYE SYMPTOMS
- [ ] DOUBLE VISION
- [ ] BLURRY VISION
- [ ] LIGHT SENSITIVITY
- [ ] EYE PAIN
- [ ] ITCHING EYES
- [ ] WEARS GLASSES
- [ ] WEARS CONTACTS

OTOLARYNGEAL
- [ ] EARACHE
- [ ] HEARING LOSS
- [ ] RINGING IN THE EARS
- [ ] EAR DISCHARGE
- [ ] DIZZINESS / VERTIGO
- [ ] NOSE BLEED
- [ ] NASAL DISCHARGE
- [ ] MOUTH SORES
- [ ] BLEEDING GUMS
- [ ] HOARSENESS
- [ ] THROAT PAIN
- [ ] WEARS HEARING AIDES
- [ ] WEARS DENTURES

NECK
- [ ] NECK PAIN
- [ ] NECK STIFFNESS
- [ ] LUMPS/SWELLING

BREAST
- [ ] BREAST PAIN
- [ ] NIPPLE DISCHARGE
- [ ] BREAST LUMP

CARDIOVASCULAR
- [ ] CHEST PAIN / DISCOMFORT
- [ ] FAST HEART RATE
- [ ] PALPITATIONS
- [ ] ANKLES SWELLING
- [ ] ACTIVITY INTOLERANCLE

PULMONARY
- [ ] SHORTNESS OF BREATH
- [ ] COUGH
- [ ] COUGHING UP BLOOD
- [ ] WHEEZING

GASTROINTESTINAL
- [ ] CHANGE IN APPETITE
- [ ] DIFFICULTY SWALLOWING
- [ ] HEARTBURN
- [ ] NAUSEA
- [ ] VOMITING
- [ ] ABDOMINAL PAIN
- [ ] DIARRHEA
- [ ] BLACK / TARRING STOOL

GENITOURINARY
- [ ] DYSURIA (PAIN/DIFFICULT)
- [ ] INCREASED FREQUENCY
- [ ] BLOOD IN URINE
- [ ] LOSS OF CONTROL

MALES:
- [ ] PENILE DISCHARGE
- [ ] ERECTION PROBLEMS
- [ ] GROIN/TESTICULAR MASS

SKIN SYMPTOMS
- [ ] PRURITUS (ITCHING)
- [ ] SKIN LESIONS
- [ ] RASHES

ENDOCRINE
- [ ] EXCESS SWEATING
- [ ] EXCESS THIRST
- [ ] LIBIDO CHANGES
- [ ] HOT / COLD INTOLERANCE

MUSCULOSKELETAL
- [ ] JOINT PAIN
- [ ] JOINT STIFFNESS
- [ ] MUSCLE ACHES
- [ ] MUSCLE WEAKNESS

NEUROLOGICAL
- [ ] DIZZINESS
- [ ] VERTIGO
- [ ] FAINTING / BLACKOUTS
- [ ] MOTOR / COORDINATION
- [ ] TREMORS / TWITCHES
- [ ] DIFF. MOVING ARM/LEG
- [ ] CHANGES IN WRITING
- [ ] SEIZURES
- [ ] SENSORY CHANGES
- [ ] NUMBNESS / TINGLING
- [ ] MEMORY LOSS
- [ ] PARALYSIS

PSYCHOLOGICAL
- [ ] SLEEP TO MUCH
- [ ] DIFF. FALLING ASLEEP
- [ ] FREQ. WAKING UP
- [ ] ANXIETY
- [ ] DEPRESSION
- [ ] UNUSUAL MOOD SWINGS
- [ ] HOPELESS